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A CLINIC

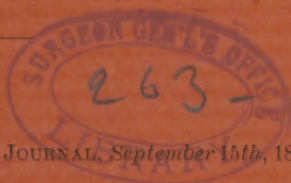
ON

Phthisis Pulmonalis, Acute and Chronic;
Acute Miliary Tuberculosis; Mitral and
Tricuspid Insufficiency; Mitral Stenosis,
Hydro-Thorax, Hydro-Pericardium,
and Chronic Pneumonia; Em-
physema.

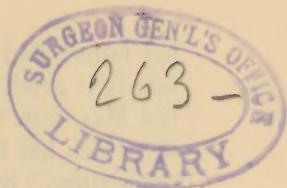
BY

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A CLINIC ON PHTHISIS PULMONALIS, ACUTE AND CHRONIC;
ACUTE MILIARY TUBERCULOSIS; MITRAL AND TRICUSPID
INSUFFICIENCY; MITRAL STENOSIS, HYDRO-THORAX, HY-
DRO-PERICARDIUM, AND CHRONIC PNEUMONIA; EMPHY-
SEMA.

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ONE cannot be too careful in the examination of a patient whose symptoms have given rise to the suspicion of a commencing phthisis. Only after repeated physical exploration, observation of the pulse, temperature and weight, close inquiry into the previous history and the existing symptoms can we arrive at a correct diagnosis. I wish more especially to direct your attention to the danger of giving undue prominence to one symptom or to one physical sign, and of considering the objective to the exclusion of the subjective symptoms. Frequently a cardiac lesion will be found as the cause of hæmoptysis and of a cough. Many patients come before us complaining of a cough when the lesion lies in the mucous membrane of the trachea, and gives no physical sign. Then, too, the condition of a patient suffering from malaria, which is frequently accompanied by a cough, may be taken for the hectic fever of phthisis. Upon physical examination, we may find at the right apex more vocal resonance than at the left; we may find the percussion note less pulmonary in quality and higher in pitch, and the expiration, on auscultation, higher in pitch and more prolonged than we do at the left apex. Do these physical signs necessarily indicate phthisis? They do not, because we often find that difference normally between the two sides. Yet I am sure that such mistakes in diagnosis do occur, bringing disquiet to the patient and discredit upon the physician. Our first patient this morning says that she is nineteen years of age;

her father died of consumption; the history of the rest of her family is good. She has had a rather dry hacking cough since last May, now ten months, at which time she had an hæmoptysis, which has been repeated in varying amounts nearly a dozen times since. She cannot remember that she has ever had night sweats. There has been loss of flesh and strength to a moderate degree. Pulse, 100; temperature, 100° M.; the respiration not materially accelerated. The finger ends are somewhat clubbed in appearance. Let us now proceed to the physical examination of her chest. We find upon inspection some limitation in the motion of the chest in the right infra-clavicular region—a sign that is of greater import than in men. Palpation develops no decided fremitus, but the higher tones of the female register make this sign unreliable. Percussion gives decrease of pulmonary resonance, with decided rise in the pitch, a sign of greater significance on the right side of the female chest than in that of the male. Auscultation reveals prolongation of the expiratory murmur high in pitch, almost bronchovesicular, both in the supra-spinatus and infra-clavicular regions of this right side, together with some fine crackling râles. Excluding the heart, its size and valvular sounds being normal, we may make the diagnosis of phthisis and of phthisis in its earlier stage. For the hæmorrhage, we will prescribe rest, small pieces of ice, and the fluid extract of ergot in 3 i. doses, when the occasion requires. Ergotin administered hypodermically is frequently used with advantage. For the cough we have to prescribe some mixture containing an opiate, not with the direct object of stopping the cough, but for the purpose of controlling it, while by the general treatment we aim to remove its exciting cause.

		Gramme.
R. Morphiæ sulphatis.....	gr. i.	.06
Acidi hydrocyanici diluti	3 ss.	2.
Syr. ipecacuanhæ.....	3 i.	5.
Syr. simplicis.....	3 ss.	20.
Mucil. acaciæ ..	q. s. ad 3 iv.	99.
M. S.	3 ii. q. 4 hours p-p.	

Cod-liver oil in 3 i. doses three times a day, with the local counter-irritation of tr. of iodine, will comprise our treatment for the present. If she finds that she is unable to take even this small amount of oil, three or four drops of ether will materially aid in its digestion. It is useless to recommend change of climate to one in her circumstances.

The next patient that comes before us has been under my observation for the past two months at the hospital. He illustrates how serviceable and indispensable digitalis is in our treatment of such conditions. At my first examination, I found him complaining of weakness, shortness of breath, cough, palpitation and swelling of the ankles and legs. He has been a sufferer from rheumatism for many years. There was œdema from his ankles to the middle of his thighs; his hands, arms, and lips were cyanotic, and there was regurgitation in the veins of the neck. Upon inspection of the cardiac area, I found that the apex beat had disappeared, but that there was decided epigastric pulsation. Auscultation revealed the position of the apex to be below and beyond its normal area, and a blowing murmur heard during systole at the apex, and one also in the tricuspid area. No murmurs in the aortic region. There were a few subcrepitant râles in the infra-scapular region unaccompanied by dulness. The diagnosis was mitral and tricuspid insufficiency with dilated hypertrophy, œdema of the lungs and lower extremities as a result of the ruptured compensation.

The treatment was infusion of digitalis with potassium acetate $\frac{1}{2}$ ss.—gr. x., to be taken every four hours. The first effects noticed were the disappearance of the jugular pulsation and a moderation of the cyanosis. To-day we find that the œdema of the lower extremities has wholly disappeared. Quite a forcible apical impulse is seen, and upon auscultation I find that the tricuspid murmur has disappeared, while the mitral regurgitant murmur is still distinct. The insufficiency of the tricuspid valve was a curable one. Disappearance of the apical impulse, while at the same time an epigastric pulsation is seen, is indicative of dilatation or hypertrophy of the right ventricle, the left ventricle being crowded back, as it were, from the chest-wall. A forcible pulsation at the epigastrium indicates hypertrophy, a weak one usually dilatation. Compensation has been restored, and under tonic doses of digitalis it may be preserved for a long time.

Again we have a patient suffering from shortness of breath, palpitation, precordial pain, and swelling of the ankles. About five years ago she had acute articular rheumatism, and has been subject to subacute attacks at various times since. We find that her legs and thighs pit upon pressure. Inspection shows us the apical impulse above the left nipple and beyond the mammil-

lary line. Why this is so, further examination must explain. Auscultation reveals no valvular murmur, but I find that the heart is irregular and intermittent in its action, and also irregular in its intermittency. Placing the stethoscope over the pulmonary area, I find decided accentuation of the second sound; over the tricuspid and mitral regions the sounds are almost indistinguishable. Examination of the chest shows upon inspection that there is very little respiratory action except in the upper part of the left side. Palpation gives absence of fremitus in the infra-scapular regions, and in the greater part of the right scapular and right axillary regions. On percussio we find flatness from the spine of the right scapula downwards, from the middle of the right axillary region and from the third right rib in front. Flatness also in the left infra-scapular and infra-axillary regions and flatness extending across the lower part of the cardiac region. The percussion note is rather dull in the right infra-clavicular region. Auscultation reveals absence of respiration and voice over the area of flatness, with increased or puerile breathing left in front, and broncho-vesicular respiration at the right apex. The interpretation of these physical signs is fluid in both pleural cavities, and also in the pericardium; the very large amount in the right side with that in the pericardial sac explains the abnormal position of the heart. Is the fluid the result of pleurisy, or is it a passive effusion? We seldom find a bilateral pleurisy; there is no history of pleuritic pain; there is decided œdema of the legs; and we have reason to suspect valvular disease of the heart. The history of rheumatism, of shortness of breath upon exertion, the irregular action of the heart, the accentuation of the pulmonary second sound, and all these evidences of an over-filled venous system are factors in arriving at the diagnosis of an obstructive lesion and of the mitral valve. Owing to the fluid, we are unable to determine how much hypertrophy or dilatation of the heart there may be. We will prescribe digitalis in $\bar{3}$ ss. doses every four hours, an occasional hydragogue purgative, as gr. $\frac{1}{16}$ of elaterium, and I would also strongly recommend in this instance the immediate use of the aspirator, as the woman is in imminent danger of drowning in her own fluids. When the œdema is excessive, puncturing the legs and thighs is a very useful expedient. I have in mind one patient who came under my observation while a resident at the Roosevelt Hospital whom

we treated very successfully in this manner. Brought to the hospital apparently moribund, in a few weeks she so far recovered as to walk about, the œdema, which was excessive, had wholly disappeared, and the punctures cicatrized without local injury. Large doses of digitalis were administered at the same time. The patient left the hospital, and about a year from that time she sent for me, and I found that from lack of proper care and treatment the compensation, which was for an aortic stenosis and a mitral insufficiency, had again become ruptured. The œdema extended up to her waist, and there was fluid in both pleural cavities, and finally œdema and congestion of the parenchyma of the lungs brought to a fatal termination a case that undoubtedly would have been lost a year earlier but for the treatment pursued, and might not have closed its history so soon had the patient been under more favorable circumstances during that year.

The next patient comes to us with a history of a decided chill on the morning of the first of January, now six weeks ago. He had fallen asleep upon a pile of coal in the place where he was employed as coal heaver. This chill was followed by a burning fever, pain in his right side, dyspnœa, and cough with glairy viscid sputa, that soon assumed a reddish tinge. He now complains of a dry cough, dyspnœa, and a sense of oppression and weakness. Inspection shows us nothing abnormal. Palpation develops decided increase in fremitus over the right inferior scapular and axillary regions. Mensuration furnishes but negative results. Percussion gives dulness from the middle of the right scapular down to the middle of the infra-scapular region. Auscultation reveals tubular breathing over the region of dulness with bronchial voice. The history and the physical signs lead us to but one conclusion, chronic pneumonia, a rare form either as the sequence of acute pneumonia or as a primary disease. In a patient that came before us about ten days ago with a history somewhat similar to this man's, you remember we found unmistakable evidences of a large excavation. There was dulness, cavernous breathing and voice, and gurgling râles near the inferior angle of the right scapula, with no evidences of consolidation at the apices. That was acute pneumonic phthisis; the patient was still well-nourished, but I have noticed a very rapid loss of weight a few weeks before the end in similar cases. A patient who came under my observa-

tion in January, 1876, with the history and physical signs of pneumonia, first developed the signs of phthisis about the tenth of February, emaciation by the last of March, and died on the seventeenth of April, acute miliary tuberculosis supervening to this pneumonic phthisis. I will relate the part of the autopsy that bears upon it, and give the pulse and temperature table for the last ten days, which is a fair example of the average temperature that was taken, and illustrates the moderate elevation that we may expect to find in acute miliary tuberculosis in this country. "Both sides, costal and pulmonary pleuræ studded with miliary tubercle. Left lung, upper lobe honey-combed with cavities, lung tissues, cheesy nodules, and red hepatization. Bronchi contain mucus and pus. Right lung, bronchitis, emphysema, and a few cheesy nodules. Intestines, ileum, a number of small ulcers with miliary tubercles in the peritoneal wall. Tubercles in omentum."

		Temperature				Temperature	
		Pulse.	Mouth.			Pulse.	Mouth.
April 8th.	A.M.	120	100 $\frac{3}{4}$ °	April 13th.	A.M.	118	100°
	P.M.	140	101		P.M.	128	100
9th.		120	98 $\frac{1}{2}$	14th.		120	98 $\frac{1}{2}$
		120	103 $\frac{3}{4}$			136	100 $\frac{3}{4}$
10th.		120	99 $\frac{1}{2}$	15th.		100	98 $\frac{1}{2}$
		120	101 $\frac{3}{4}$			120	101
11th.		128	101	16th.		120	98 $\frac{1}{2}$
		128	103			140	101
12th.		130	99 $\frac{1}{4}$	17th.		120	98 $\frac{1}{2}$
		132	103			120	102

We now have for examination a patient who is suffering from dyspnœa and a cough. He has been subject to cough, especially during the winter season, for the past fifteen years. There have been neither hæmoptysis nor night sweats. Upon inspection, we see that the accessory respiratory muscles are brought prominently into play during inspiration. There is bulging of the chest-wall, most marked in the left infra-axillary region. There is depression rather than expansion at the lower part of the chest wall during inspiration. Palpation develops little if any fremitus. Mensuration shows that the difference between the extreme expiration and forced inspiration is very little as compared with that in the normal chest. Percussion gives a note of low pitch and increased intensity, exaggerated pulmonary resonance. The auscultatory signs are prolonged low-pitched expiration, more noticeable on the left side of the chest,

with some sibilant breathing on the right side. We cannot expect to cure this emphysema. For the bronchitis and what spasmodic element may combine to increase the dyspnoea, we will prescribe this mixture :

	Gramma.
R Potassii iodidi	℥ i. 4.
Ammonii carbonatis	℥ ss. 2.
Spiritus ætheris co	℥ ss. 13.50
Syr. pruni. virginianæ	℥ i. 40.
Aquæ.....	ad ℥ iv. 75.
M. S. ℥ ii. t. i. d. pp. (well diluted).	

Also ℥ i. doses of cod-liver oil three times a day after meals. We have thus been able to make practical application of our method of physical diagnosis. You have seen the importance of giving due weight to the subjective as well as the objective symptoms. The element of precision that has been added to our appreciation of the patient's condition, by physical exploration, is inestimable.

